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ABSTRACT

This article reviews the development of Medicaid (MA) reimbursement for medically related special education (SE) services and describes a MA assistance project for schools in Arkansas. The 1988 Medicare Catastrophic Coverage Act (Public Law 100-360) allowed medically related special education services to be covered by MA. However, schools have been slow to participate in the MA program for SE. The University of Arkansas Department of Pediatrics developed an MA program for public schools. The Medical College Physicians Groups (the faculty practice billing system) files claims on behalf of schools districts using MA provider numbers assigned to each school district. Electronic data transfer between the billing system and the MA claims processor allows rapid reimbursement of schools. A fee is charged to cover costs based on a percentage of the amount billed. During the first year of the project (1989-1990), 23 of the 325 Arkansas school districts participated in the project. The project billed for 297 students yielding $76,161 in reimbursements, 83 percent of the claimed amount. The mean claim per year per student of the project schools is $256, lower than a statewide average reimbursement of $1,133 per MA eligible schoolchild. Improved coordination between Medicaid and special education programs addresses problems in funding relating services. It is anticipated that related services funded by MA will expand to include psychometric testing, counseling services, skilled nursing care, and other services. (KS)

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Rural Special Education and Medicaid: Meeting a Challenge for the 1990s

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Rural Special Education and Medicaid: Meeting A Challenge for the 1990s

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Medicaid (MA) reimbursement is now possible for medically related special education (SE) services. The populations served by MA and SE are at risk from low family income and handicapping conditions that significantly affect the ability to learn and perform in school. This article reviews the development of the relationship between these two important programs for children. We describe a MA assistance project for schools devised by a University Department of Pediatrics and characteristics and reimbursement of school districts participating in MA.

INTRODUCTION The histories of MA and special education merit review. MA began in 1965 as Title XIX of the Social Security Act to provide medical care to the poor. In 1974 60% of the nation's handicapped children were not receiving appropriate educational services.(1) In 1975 the Education for the Handicapped Act-Public Law 94-142 (EHA) mandated public school special education programs that included related services including "transportation and such developmental, corrective, and other supportive services as are required to assist a handicapped child to benefit from special education" to children traditionally unserved or underserved.

In 1982 the Department of Health and Human Services' Health Care Finance Administration(HCFA) determined any service included in a SE pupil's Individual Education Plan under the EHA was the financial responsibility of the school district. In 1986 EHA was amended to extend service mandates to the third birthday by passage of PL 99-457. Section 202 of Public Law 99-457 stated "no other agencies responsibilities are limited or reduced by the new law, new funds can not be used to supplant existing state and federal funds and that states cannot reduce or alter existing eligibility and funding for medical and other health services under MA and MCH [Federal Maternal and Child Health-Title V] funding". Also in 1986 the General Accounting Office recommended changing the law to allow MA to pay for related services that typically would have been paid if EHA was not in effect. (2)

In 1987 a court ruling stated "the relevant question in determining whether services are MA reimbursable is whether the services are 'medical assistance' "and that HCFA "may not determine whether a service is included in the MA program by sole reference to the state's special education law. The Secretary of HHS must make an inquiry into the nature of the services not just into what they are called or who provides them". (3)

In 1988 the Medicare Catastrophic Coverage Act Public Law PL 100-360 stated, "Nothing in this law shall be construed as prohibiting or restricting or authorizing the secretary to prohibit or restrict payment under subsection (a) for medical assistance for covered services furnished to a handicapped child because such services are included in the child's individual education program established pursuant to part B of the Education Handicapped Act or furnished to a handicapped infant or toddler because such services are included in the child's individualized family service plan adopted pursuant to part H of such Act". While much of the Medicare Catastrophic Coverage Act was repealed, the above language was retained, allowing related services to be covered by MA. Schools thus are eligible to receive MA federal matching funds for those services.

Schools have been slow to participate in the MA program for SE. As of April 1990 (school year 1989-90) MA funding of SE was occurring in only twelve states (four states on a pilot basis only). For school year 1990-91 22 states project using MA funds for SE (eight on a pilot basis only). (4) Only two states, Iowa and Connecticut, require MA funding of related services for SE pupils. (5,6)

METHODS August 1, 1989, the Arkansas Department of Human Services allowed school districts and the state's 16 regional multidistrict educational cooperatives (serving ages 3-5 in early intervention programs) to enroll as MA providers for occupational, physical and speech therapies. (7) Arkansas educators remained reluctant to become involved in accessing MA for SE services. Reasons given included, "too complicated", "takes too long to get our money", "parents won't cooperate with providing MA information", and "what is MA?".

Based on extensive experience with MA the Section of Community Pediatrics and Public Policy of the Department of Pediatrics, University of Arkansas for Medical Sciences College of Medicine, developed a MA program for public schools. The Medical College Physicians Group (the faculty practice billing system) files claims on behalf of school districts using MA provider numbers assigned to each school district. This allows local districts access to data processing and administrative expertise with the state and federal MA program. Electronic data transfer between the billing system and the MA claims processor allows rapid reimbursement of schools. Tracking of the status of each claim, particularly those initially denied, maximizes ultimate reimbursement. A fee has been charged to cover costs based on a percentage of the amount billed. A cost based reimbursement will be developed. School

districts are reimbursed directly by MA at the MA matching rate for Arkansas of 3:1.

Arkansas has many small school districts - 325 districts in a state of 2.1 million population, mostly rural. In addition the state is divided into 16 regional educational cooperatives. All PL 99-457 services for 3-5 year olds are delivered through these cooperatives. Many districts also use cooperative based personnel to deliver SE related services to school aged pupils. The Department of Pediatrics initially approached schools through the Cooperative directors and subsequently through individual school districts.

Information from school participation was obtained from the Arkansas Department of Education. Reimbursement data was provided by the UAMS faculty practice Information Services and the Departments of Education and Human Services. Medicaid information is from the American Academy of Pediatrics Department of Research state Medicaid reports.

RESULTS Table 1 provides descriptive information from the first year of the project.

TABLE I 1989-90 SCHOOL YEAR

# of districts statewide	325
# of districts* in project	23
# student billing	297
MA charges/ reimbursement	$91,117 $76,161
% claims paid**	83%
mean claim/year	$256

*17 districts and 6 cooperatives
**rejected for "third party liability", i.e. family has some private insurance.

It is not possible from available data to determine total MA costs for pupils with related services paid by MA. The $256 average claim per year is not large in comparison to a statewide average reimbursement of $1133 per year per MA eligible schoolage child. 83% of claims were paid by MA. Most of the 17% rejected were on the basis of some private health insurance in the family or ineligibility. This issue of rejection for third party liability is addressed in the discussion.

Table 2 compares the 17 school districts to the 51 districts billing independently and the 254 districts not participating in MA at all. The mean and median enrollments in districts in the project were larger than in the other two groups although the difference was not statistically different. For districts in the project MA participation was lower and SE enrollment higher than in project districts:

Table 2 Comparison of Participating School Districts 1989-90*

	State total N=325	Project N=17	Other** N=51	No MA participation N=254
Total Enrollment				
	434,200	37,657	6,996	242,391
Mean	1,336	2,215	1,901	954
Median	650	1,561	771	614
MA enrolled	30,942	2,086	7,852	17,290
%MA	7.1%	5.5%	8.1%	7.1%
SE enrollment				
	43,128	3,892	9,454	24,811
%SE	9.9%	10.3%	9.7%	10.2%

* Does not include cooperatives
**Excludes the three large urban school districts
Mean enrollment, MA eligible, and SE enrollment do not differ significantly, P>.05.

DISCUSSION MA and SE are two entitlement programs administered by the individual states, utilizing both state and federal funds. There are variations in both programs in eligibility and benefits from state to state. Educators have reason to feel uneasy about MA, a new program involving Federal funds as payment source. The EHA mandated states to provide an array of new services, authorizing a Federal share of 40% of states' SE costs. Appropriations have fallen far short of this, never higher than 12% and currently provide only 9% of states' costs. Meanwhile there have been no reductions in the level of services districts are required to provide. (1)

In a series of articles Palfrey and her colleagues have identified areas of concern in provision of related services in five urban communities. These districts range in size from 19,000-116,000 pupils and are much larger than districts involved in the Medicaid assistance project. They have found pervasive problems in funding SE related services. MA will provide new resources for educators.(8,9,10,11) Morse has recently reviewed the relationship between Title V of the Social Security Act (Maternal and Child Health Block Grant) and preschool and school age special education law. She found: **1.** local and state information and resource sharing can unify activities between health and education and **2.** a need for improved third party funding. (12)

Although both Medicaid and special education programs are less than perfect, improved coordination between these programs for children with special needs addresses identified problems in funding related services .

Most states currently not accessing MA for SE are studying the feasibility of such funding. Six states currently bill family's private insurance for SE medically related services. This may jeopardize a child's and/or family's insurability over time by exhausting lifetime policy limits or establishing the presence of a "pre-existing condition". A recent appeals court decision ruled private insurers need not pay for related services if the policy excludes services "which the subscriber is entitled to receive from a governmental agency or unit without cost". (13) We feel that billing private insurance violates the spirit of free public education and do not provide for billing private insurance.

The Early Periodic Screening Diagnosis and Treatment (EPSDT) component of MA was added in 1967 to provide comprehensive well child care. In addition MA coverage of services to children participating in EPSDT was allowed even if not provided to all others in the MA program. The Omnibus Budget Reconciliation Act of 1989 requires coverage of any needs found through EPSDT regardless of whether indicated services are included in the State's MA plan. In many states this provision allows or extends services previously not covered or limited to units of service allowed per year. In addition OBRA 1989 added children up to age 6 in families up to 133% of poverty to MA eligibility. OBRA 1990, as of April 1991 mandated coverage to 100% of the poverty level for children age six to nineteen. The ages covered by those income guidelines will increase by one year of age annually. All children up to age 19 will be covered in 2001. These changes have led to both increased numbers of young children eligible for Medicaid and the scope of services they receive.

In 1987 Palfrey and her group reported only 28.7% of children with educationally handicapping conditions were identified by age five. (9) The improved coverage of younger children and EPSDT expanded mandates may improve identification of potential educational problems in kindergarten and lower grades. These changes can bring about improved detection of problems by medical personnel and provision of MA funds to districts.

CONCLUSIONS The American Academy of Pediatrics has urged pediatricians to take a broad role in SE programs. (14) We found a role for existing resources in the Department of Pediatrics to improve funding of SE. Complex annual federal and state MA changes suggest that school districts can benefit from outside expertise. We support use of MA as it encourages identification and treatment at younger ages through broadened income eligibility. We expect that related services funded by MA will expand to include other related services. These should include psychometric testing, counseling services, skilled nursing care, and other services. Medical assessment and care are already eligible for MA reimbursement under existing mechanisms. As stated in the Academy's policy statement, the role for pediatricians in prescribing and monitoring SE services should be greater. Similar expansion will occur in all states, depending on the services covered prior to OBRA 1989. Schools now have a

specific reason to assist the health and social services departments to identify children eligible but not enrolled in MA and/or EPSDT.

In summary, MA offers an underutilized source of payment for many SE children. Organizations such as University Departments of Pediatrics, state programs for special needs children, or county and state health departments with experience in both the needs of special education pupils and the state MA program can assist schools in use of MA. We hope to see this program replicated.

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